# COMMUNITY MENTAL HEALTH

# SERVICES CLINIC SYSTEM

# STAFF SAFETY & SECURITY REVIEW REPORT

**Submitted by:**

**Security Review Committee**
**November, 1991**

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92-03268/

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# COMMUNITY MENTAL HEALTH SERVICES CLINIC SYSTEM

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## I INTRODUCTION

On August 27, 1991, Inette John, a Mental Health Therapist, was fatally stabbed in her office in the 108 Street Community Mental Health Clinic, Edmonton. As a result of the fatality, Alberta Health formed a review committee to:

- Review all aspects of security and personal safety within the 108 St. Clinic with specific focus on the circumstances surrounding Inette John's homicide.

- On a broader basis, assess current safety and security provisions within the Community Mental Health Services clinic system throughout the province, and make recommendations.

The first aspect has been addressed in the comprehensive Alberta Health - Mental Health Division Fatality Review - Inette John. What follows is a companion document to the first report and addresses the second aspect - the province wide review.

This report is mandated by and respectfully submitted to the Deputy Minister of Alberta Health

### Methodology

In approaching the province wide review, the Committee requested each Community Mental Health Services Region to forward a submission containing existing policies and procedures, Incident Reports from the past two years, and a qualitative assessment of the region describing clinic facilities and exposure to risk.

Information available to the Committee was derived from the following sources:

- Fatality Review - Inette John was critically reviewed to determine the appropriateness of the fifteen recommendations from a province wide perspective.

- Incident Reports completed by Community Mental Health Services staff following high risk or "near miss" incidents.

- Alberta Mental Health Management Planning System's Caution Indicator Report for the Province.

- General Province wide policies of the Community Mental Health Services Branch and the policies and procedures from each of the six regions which affect the safety and security of staff.

- Visits and discussions by Committee members with the six regions in order to determine formal and informal policies, procedures and practices, physical/structural issues, unique regional issues or risks. Earlier written submissions from the regions were also reviewed within this context.

- Various gratuitous representations made by interested and concerned parties were received and reviewed.

The information gathered from the above sources was critically assessed by the Committee as a whole and recommendations have been made based on the conclusions drawn. The report that follows outlines the detail of the Committee's findings, analysis, conclusions, and recommendations structured around the issues of program organization and mandate, physical plant and security in the clinics, existing policies and procedures, the prevalence of risk, the perception of risk, and conflicting priorities within the Community Mental Health Services system.

## II PROGRAM ORGANIZATION/MANDATE

### Mandate

The Mental Health Division, Community Mental Health Services Branch is responsible for ensuring the availability of high quality treatment and support services for the mentally ill residents of Alberta.

The purpose of Community Mental Health Services clinics is to provide diagnostic assessment and treatment of clients of all ages throughout the province; consultation with general practitioners, nursing homes, courts, correctional institutions, public health, child welfare, schools, and other community agencies; and follow-up of persons released from mental hospitals, including placement in residential and non-residential support services in the community.

Priority groups for service across the province are the chronically and acutely mentally ill, children, elderly, and Native populations.

### Organisation

Community Mental Health Services are delivered through six regions, each having its own Director, who reports to the Executive Director of Community Mental Health Services. Each region also has a Regional Manager for Community Agency Support Services who reports

to the Regional Director and is responsible for the adminstration of the Approved Home Program and the contracts with private agencies, delivering the various community support programs.

Community Mental Health Services are provided from 52 permanently staffed clinic locations and an additional 38 visiting clinic locations throughout the Province. Complete listing of locations is included in Appendix I.

Although regions vary from one another in geography, population densities, and organizational structure/staffing levels; all regions generally follow a multi-disciplinary team approach to service delivery. Each region has a number of teams run by a Manager or Supervisor, supported by various disciplines. In the larger, urban regions, a multi-disciplinary program approach replaces the rural regions' multi-disciplinary generalist approach to service delivery. The number of clinics present in each region ranges from six to fourteen clinic sites. A number of these are one person clinics often isolated in rural areas. Frequently the travel time between the clinic and the supervisor or collegial clinic site is two to three hours away.

All regions maintain some form of supervisory model, in which new incumbents are orientated to their service and area. They also become participants in team meetings and one on one supervisory sessions.

**Client Population**

Annually, in excess of 20,000 clients on the average are served. Of approximately 13,000 new cases seen each year, 40% are self referrals, another 19% are referred by a relative or friend, and 20% referred by a physician. The remainder are referred by hospitals, schools, Child Welfare, Legal Services, etc.

New clients are screened and clinically assessed by a therapist before entering treatment. This is generally referred to as an "intake assessment".

Each Region has an intake system but this varies from clinic to clinic within the Region. It may involve pre-screening, waiting lists, appointments, or walk-in referrals.

Therapists spend an average of about six hours total with each client, of which 23% (75 minutes) is spent in assessments.

About half of the clients seen (45%) suffer from a mixture of family and psychosocial problems, stress and adjustment reactions. Typically they attend the clinic for a few weeks of counselling-based therapy with good recovery.

The next largest group (22%) suffer from quite different problems of functional psychoses. These include illnesses such as schizophrenia, major depression, and mania. Typically they require much longer treatment lasting months or even for a lifetime, based on the need for medication and specialized programs (eg. teaching living, social, and vocational skills). There are significant geographical differences with this group, for instance, accounting for 44% of the open cases in Edmonton Region compared to 15% of open cases in the more rural North West Region.

Other client groups which are small in number, but significant in terms of risks are those with a primary diagnosis of personality disorder (4%), substance abuse (3%), and organic psychosis (2%). 24% of cases seen are under the age of eighteen.

Examples of special problems include clients who have a combination of severe mental illness, substance abuse, anti-social behaviour, and often marginal co-operation and little insight.

## Violence and Mental Illness

It is important to recognize that violence is a complex phenomenon and in most cases is unrelated to mental illness. It is reported that most experts feel that people suffering from mental illness as a whole are no more likely to commit acts of violence than the population at large. There is a suggestion from recent studies however, that violence by the mentally ill is increasing and in particular those mentally ill people who have previously been hospitalized. There are at least three diagnostic groups where the risk of violence is higher:

1) **Organic Mental Disorders** - These are conditions where a person's mental state is altered by a physical process; for instance alcohol, drugs, or an illness such as Alzheimers disease. As mentioned above, these conditions are seen relatively infrequently in the mental health clinics. Violence associated with them is usually impulsive rather than premeditated.

2) **Personality Disorders** - These are not illnesses per se, but are abnormalities of personality, for instance the anti-social type. Although a lot of violence in society is committed by this sort of person, as mentioned above, it is relatively uncommon in the mental health clinics except in clinics where there is a lot of forensic work for the courts. Violence associated with this is usually reactive (to not getting what you want, feeling slighted, etc.) or premeditated (for personal advantage, theft, etc.).

3) **Functional Psychoses** - These are seen relatively frequently in the mental health clinics, especially in Edmonton. In mania

violence occurs during the acute phase and is impulsive. In schizophrenia violence can be associated with hallucinations, in which case it is impulsive, or with delusional ideas, in which case it can be either impulsive or premeditated. Premeditated violence in an untreated delusional schizophrenic may be directed at famous people, close family members, physicians, or therapists. With treatment, the risk is considerably decreased.

**Analysis**

The above review confirms that the mental health clinics carry a large caseload, providing services to a wide range of client groups. Most clients pose no threat whatsoever. There are a significant number of cases, however, where there is a risk of violence, occasionally severe.

In reviewing the clinic system, it appears that in the larger centralized clinics, fewer contacts are on record with other care-givers, a client's family, and other resources. In the smaller area clinics, there is increased contact with other resources and care-givers. This increases the "contact" with the client and therefore improves the knowledge of the level of risk. The increased levels of functional psychoses in the cities, but especially Edmonton, would likely cause increased risk compared to Calgary, while rural areas would have the lowest levels of risk.

The best prediction of violence is through knowledge of the client. Situations where the client is unknown or has not been seen for some time are most risky. Factors such as the presence of the disorders mentioned above, alcohol or drug use, past history of violence, the expression of violent intentions, past history of child abuse or domestic violence and certain demographic characteristics, are all used by therapists to predict violence.

It is noteworthy that across the province every region encourages therapists to make an assessment of risk. However, this assessment of risk is found only in the mental status examination on the patient's chart. It doesn't appear on the Alberta Mental Health Management Planning System (AMHMPS) computer system unless a Caution Indicator is completed and placed at the front of the client's file.

There is no consistency of mandatory consultation to psychiatry regarding "at risk" diagnostic categories.

Also noted is the lack of a central registry. Clients may receive services from a variety of providers, each being unknown to the other, with no reporting system alerting other providers of a client's "dangerous" behaviour.

Finally, specialist forensic programs which deal with a high number of dangerous aggressive patients are limited only to Calgary and Edmonton. In rural regions the general services deal with these patients. Again this seems to be an area of increased risk for the therapist.

## III PHYSICAL PLANT/SECURITY

### Findings

Information for this portion of the report was gathered from safety and security assessments prepared for the Committee by various regions; information reported by Committee Members as they travelled to the regions, met with safety contact people, and reviewed specific clinic facilities; and from various input by Community Mental Health, Health Accommodations, PWSS Security Assessment, and Family and Social Services Accommodations staff.

As previously described, clinics vary in size from the large urban clinics to the use of an office by a single therapist one day per month. They vary in age from those having been constructed as joint Social Service and Community Health offices a number of years ago to free-standing Community Mental Health Clinics opened as recently as October of 1991. As indicated, some clinics are free-standing, some share space with Alberta Family and Social Services, with the local Public Health Unit, or with other government departments or agencies. In some instances, the clinics are located within Provincial Buildings while in others they are located in private office buildings or store front operations.

There is also great diversity in the interior design and quality of the various clinics in terms of safety features, special program features (eg. therapy rooms, observation rooms, etc.), soundproofing, and furnishings (office/interview as well as therapy). While newer clinics tend to have a barrier/counter for the reception area, some type of buzzer/alarm system, an increased level of soundproofing, and specially designed therapy and observation space, there are no standards for clinic construction. Great diversity also exists in the arrangement and furnishing of therapist offices (interview rooms) across the province.

### Analysis

Because of the diversity in size, age, location, and other physical attributes of the various clinics, it is difficult to generalize as to common problems or issues. However, there are certain themes or concerns that were frequently raised as part of the review of physical space provided to the clinics. At the risk of incorrectly implying that <u>all</u> clinics have the same issues or problems, the

following common themes are offered:

Isolation

Isolation is a multi-dimensional problem facing the entire Community Mental Health clinic structure. It results from the following factors:

- **Within a building** based on the physical proximity of the clinic to other agencies. Some permanent and visiting clinics are located in remote or isolated areas of provincial or private buildings.

- **Within a clinic**, clerical and clinical staff can be isolated or "cut off" due to design or distance. Many clinic locations throughout the province do not have any linking mechanism (buzzer/alarm) to benefit either therapists or the receptionist.

- Most clinics are located behind **solid general office doors** which in the interest of providing security and client confidentiality, offer no ability for staff to determine who is about to enter the clinic or for passer's by to determine if anyone in the clinic is in danger. Some clinics are equipped with door enunciators which indicate when someone has entered the clinic. They do not, however, prevent someone from entering.

- Beyond the physical issues, **the staffing levels** of the clinic promote isolation in that in a two to three person clinic, any absences by either the receptionist or the therapist potentially puts the other at risk. A single therapist travelling to a **visiting clinic** is by definition at risk as well. As a result, in some locations two therapists travel together to visiting clinics. Lastly, a single therapist on a **home visit** is also at risk due to isolation.

Physical Layout/Design

From a staff safety perspective, there are three critical zones within a clinic:

- **Waiting/reception areas** across the province vary widely. Older clinics tend to have a more "open" and "comfortable" approach for clients. Reception points were intentionally designed to be without barriers. On one hand this potentially increases the risk of a receptionist being attacked. On the other hand, if there is free movement completely around the receptionist desk the likelihood of entrapment in a semi- restricted area is lessened. Many clinics offer children's play areas in the waiting area. Only one (Medicine Hat) has an intake office off

the waiting area, and it has been unusable for the past year due to construction deficiencies.

- **Therapist Offices (Interview Rooms)** also vary widely in terms of the level and quality of soundproofing, presence and type of interior windows, amount and arrangement of furniture, presence of alert buzzer/alarm mechanism, and lock on door. Generally, from the perspective of client confidentiality, the level and quality of soundproofing provided for therapist offices is considered to be insufficient. Interior windows are intended to facilitate visual surveillance/observation of what is going on inside the therapist office. In many clinics windows are either heavily "frosted" or draped so that their intended purpose is defeated. In most instances, like the 108 St. Building, offices are arranged so that the desk is by the window and the client is seated by the door. This arrangement does not provide a barrier between the therapist and the client and does not facilitate easy access to the door by the therapist. The presence of locks on some doors only compounds the potential for entrapment.

- **Special Purpose Space** such as group and play therapy rooms have been provided in the newer clinics but are either shared with Family & Social Services or non-existent in older ones. The intent is that the activities in these rooms be observable by other staff sitting in "observation" rooms behind one-way mirrors. While the group rooms tend to be used after hours in many clinics, which raises some other safety questions, the rooms themselves are not seen as being problematic.

In addition, because the clinic requires so many enclosed spaces (offices/interview rooms, therapy/observation rooms, file rooms, medication rooms) the end result is often the prevalence of hallways throughout the clinic. Generally, the larger the clinic the more "maze-like" the hallway system, with blind corners and more potential for problems escorting clients to offices or responding to emergencies. In many clinics these hallways lead to "dead ends" as there is only one way in and out. Once again, the possibility for entrapment within the clinic exists by someone blocking either the single doorway or any point along the hallway into the back of the clinic.

Co-location With Another Agency

Co-location is also a multi-dimensional issue. There are positive aspects with respect to client anonymity entering the clinic, shared resources and specialty space, and limiting the tendency toward isolation. Each of these positive aspects though can become negative given personalities and lack of cooperation among staff so that client confidentiality is compromised, resources and safe specialty space are unavailable, and adequacy of response in an

emergency is questionable. However, there is a belief that the isolation problem has been solved in some locations by co-locating with another agency. This has occurred both as a result of having other people in the vicinity while therapy is being conducted as well as the other agency being the recipient of the distress call/buzzer/alarm where so equipped. The actual quality and capability of the agencies response is unknown.

### Attention to Safety Details Within the Clinic

Following the incident in the 108 St. Clinic, Edmonton Police Services conducted a review of the clinic paying particular attention to detail as it related to safety and security threats in the office at that time (see Fatality Review Appendix). Lessons learned from that report are applicable province-wide. During the recent limited number of site visits, a number of clinics had such items as message "spikes," letter openers, and flower vases within ready access of clients or visitors. As well, some concern was expressed over the type of individual decor placed in the therapist's offices or the reception area (eg. sharp wall sculpture, painted rock, etc.).

## IV POLICIES AND PROCEDURES

### Findings

Community Mental Health Services Regional Directors were requested to provide the Review Committee with existing policies and procedures affecting staff safety and security. All regions responded to the request.

The following topic areas were addressed in the policies and procedures received for review:

- Caution Indicators
- Incident Reports
- Problem or Violent Clients in the Clinic or the Reception Area
- After Hours Security
- Home Visits or Violent Clients Out of the Clinic
- General Staff/Client Safety
- Guidelines for Handling Difficult Clients
- Dealing With Threats
- Intake Procedures
- Sensitive Situation Alerts
- Orientation of New Personnel
- Medical Emergencies
- Review of Unusual Circumstances
- Annual Review of Incident Reports
- Needle Stick Injury/Exposure to Body Fluids (re: HIV/HBV

infection).

Not all regions forwarded documentation relating to all topic areas.

In addition, the following Mental Health Division provincial policy directives were reviewed:

Staff Orientation
Caution Indicators
Fatalities Review
Sensitive Situation Alerts
Safety
Clients with AIDS

**Analysis**

Formal policies and procedures generally form the basis for a plan of action. Ideally, the written documents should be clear, direct, action oriented, and communicated to all staff. The procedures should also be practice drilled from time to time in order to maintain an appropriate state of "readiness" as well as to serve as a training exercise for all staff who commenced since the last drill. A practice drill would also help to identify the appropriateness of the stated actions and responsibilities so that they can be amended, if necessary, prior to a serious incident taking place. Community Mental Health Services policies and procedures will be evaluated against this "standard."

While there was a certain commonality in regional policy topics, the level of detail and the procedural direction varied considerably between regions. Completion of a composite analysis of all policy and procedural direction in the provincial Community Mental Health Services system led to the following observations:

- While a common policy theme was evident across the regions on many issues, there was no clear direction on a provincial basis other than statements that a regional policy should be developed (eg. managing violent or potentially violent clients).

- Most topic areas could benefit from additional clarification and insight as a result of the Inette John Fatality Review.

- Generally, existing policies and procedures are written from the perspective that an incident involving injury to the client is possible, as opposed to injury to staff.

- Only limited attention has been given to practice drilling and effectiveness testing of emergency procedures. This fact in addition to the evidently "unforeseen" possibility that injury

could occur to staff members, would suggest a lack of emergency "preparedness" within much of the clinic system.

- The Area Clinic Manager has extensive safety responsibilities according to procedures (see further elaboration below).

According to many existing policies and procedures, Area Clinic Managers have the primary responsibility for: ensuring that new clinical staff are trained; responding to problem behaviour; backing up an individual therapist in a physically threatening situation; providing consultation to the therapist in handling actively homicidal or suicidal clients; taking charge in various clinical emergencies; and reviewing specific requests for therapists to conduct home visits or after hours therapy sessions. The ability of an incumbent Area Clinic Manager to function in the defined way is suspect. It must be questioned how an individual located in another clinic and frequently travelling throughout a large geographical area can adequately fulfil these numerous "immediate" safety response requirements.

As many of the recommendations of this Committee are procedural in nature (eg. intake processes, critical incident reporting/ debriefing, staff orientation, and disaster/emergency evacuation plans), the relevance of enhanced policy and procedure documents and processes is increased. Some degree of standardization of content and process must exist throughout the province to ensure that broader safety dimensions and recommendations are realized.

## V PREVALENCE OF RISK

It is a given that due to the characteristics of the client population and the mandate of the Mental Health Division to service that population, the personal safety and security of Community Mental Health Services employees throughout the province is at risk. The reality of this risk was abruptly made clear by the murder of Inette John.

An unanswered question from the fatality review of Inette John, however, relates to assessing the severity and magnitude of threatening behaviour in the Community Mental Health Services clinic system province wide. This section of the report attempts to quantify and describe the risks under which employees in the system must work. Information in this section is based on the formal Incident Report and Caution Indicator reporting systems.

### Incident Reports

#### Background Information

The Community Mental Health Services clinic system has a

requirement that client "incidents" be reported. While the implication seems to be that behaviour of an unusual, violent, disruptive, or lethal nature be reported, there is no common or clear definition as what constitutes an "incident.' Each region has its own policy, procedure, process and format for reporting and reviewing these incidents.

The Committee collected and reviewed completed Incident Reports from the Community Mental Health Services clinic system but focused only on those reports describing client behaviour which presented a risk, or potential risk, to employees of Alberta Mental Health. The reports covered a two year period from April of 1989 to May of 1991.

The regional breakdown of reports describing risk or potential risks to employees is as follows:

| | |
|---|---|
| Northeast Region | 0 incidents |
| Northwest Region | 4 incidents |
| Edmonton Region | 1 incident |
| Central Region | 4 incidents |
| Calgary Region | 1 incident |
| South Region | 2 incidents |
| Total | 12 incidents |

Most of the above reports depict angry or verbally abusive behaviour, although some depict aggressive behaviour resulting in property damage (eg: picture being smashed) or threats of property damage. One Incident Report describes a client following a therapist home. A number of them describe threats of personal harm to a therapist.

Three Incident Reports describe aggressive behaviour directly focused at employees including grabbing, throwing coffee and one attack with a knife at a client's home.

One other incident resulted in an injury to a hand of an employee, who had to intervene when a client attacked his mother.

Analysis

Based on a review of the Incident Reports received, it is apparent that potential personal risk to employees of the Community Mental Health Services clinic system does exist. Unfortunately, the incident reporting mechanism as it currently exists cannot be relied on to quantify that risk. The number of Incident Reports that depict potential risk to employees was small (12 reports), given the high number of therapist/client interactions across the province over the last two years. Employees appear to have handled the reported situations well.

Notwithstanding the minimal number of incidents reported, the Committee's opinion is that there is an inherent risk of personal safety to employees in the Community Mental Health Services system, and believes that Alberta Health and the Mental Health Division must ensure appropriate security measures are implemented.

It is the Committee's belief that the low number of Incident Reports touching on individual safety does not only reflect the infrequency of this type of incident, but also points toward significant problems with the overall documentation and reporting system. This belief is based on additional evidence provided to the Committee through discussions with staff and designated regional contacts throughout the province.

The following observations are made with respect the incident reporting procedures:

- There appears to be a significant tendency to under report risk or potential risk situations on the formal Incident Report form. Reporting of these types of incidents tends to occur through professional contact and consultation at the worksite or regional level.

- There is no consistent provincial policy or procedure surrounding incident reporting.

- The definition of a critical incident is not consistent or clearly understood.

- There is not a consistent awareness throughout the province that incident reporting needs to occur.

- There is not a standard format for the completion of incident reports.

- There is no consistent orientation or training for employees with respect to documentation of critical incidents and completion of incident reports.

- There is no standard routing of incident reports at the clinic regional or provincial levels for review, analysis, and feedback.

An additional dimension of the incident reporting issue, is that it is currently implied that behaviour or incidents worthy of reporting are those which are highly unusual, abnormal, or otherwise significant according to the judgement of the individual therapist. The Committee recognizes, however, that what clinical staff view as "normal" behaviour may or may not be "safe" behaviour. It is further recognized that what clerical staff view

as "normal" or "acceptable" may well be different from the views of professional staff. No identifiable behavioral limits seem to exist with respect to client behaviour in the waiting/reception area, in the therapist offices, or in group therapy sessions beyond which the client is removed, evasive action is taken, or the incident is reported.

Although the volume of Incident Reports involving personal risk to employees is small, the Committee's trust in the accuracy and completeness of the reporting mechanism is also small.

## Caution Indicators

### Background Information

The computerized Alberta Mental Health Management Planning System (AMHMPS), maintains a Caution Indicator reporting mechanism in addition to the computerized client file (registration, termination, and contact forms). This mechanism serves to alert divisional staff of existing client conditions which may influence the treatment and/or case management of the individual.

A Caution Indicator form becomes a permanent part of the client file. Two major topic areas to be considered in the use of a Caution Indicator are Medical Conditions and Suicide/Abuse/ Violence.

Cancellation of a Caution Indicator occurs only if the noted condition has abated. Some conditions are not receptive to treatment. Therefore a Caution Indicator could remain in effect permanently (eg. - medical condition).

### Findings

The Committee obtained a province wide "snapshot" from AMHMPS, of all of the Caution Indicators on record as of October, 1991. There was a total of over 2,000 cautions related to over 7,000 open cases. Most of these related to suicidal behaviour and non-violent/abusive conditions (eg. - medical conditions) and were not considered in this review. However, 331 cautions related to "high risk" categories which did correlate with violence, and their frequency of occurrence, is contained in the following table.

Clinically, a history of violence or acting out towards others is considered by many to be one of the best predictors of reoccurrence. Suicidal behaviour therefore was not included in the table (914 Caution Indicators are recorded in that category).

Caution Indicators - October, 1991

| CATEGORY | FREQUENCY/INCIDENCE |
|---|---|
| HOMICIDAL THREATS/BEHAVIOUR | 35 |
| IMPULSIVE BEHAVIOUR | 108 |
| PERPETRATORS OF ABUSE (Children/Elderly/Spouse) | 64 |
| SUBSTANCE ABUSE | 269 |
| VIOLENT/PHYSICALLY ABUSIVE | 124 |

This table indicates a total of 331 caution indicators within the provincial clinic system, with an inclination or predisposition for violence against others as measured by a "caution" on the client file. This figure would be 600 if the Substance Abuse category is included.

Based on provincial averages, this represents approximately 200-210 clients (or 350-400 including Substance Abuse category) who have one or more of the above caution indicators on their file.

Analysis

In reference to the number of over 7000 open cases, 200-210 of these are judged by the therapist as having a proclivity towards harming others. These occur particularly in certain diagnostic categories, for instance the functional psychoses. This information is noteworthy in supporting the view that there is sufficient potential personal risk for employees of the Community Mental Health Services clinic system to warrant continued attention to safety and security issues.

## VI PERCEPTION/MANAGEMENT OF RISK

It is apparent that even in the few weeks since the murder of Inette John in Edmonton, the perception of risk varies greatly throughout the Community Mental Health Services system. In Edmonton and Calgary, concern for personal safety has increased considerably as other staff see themselves as being "at risk". This appears to be at least partly due to the proximity to facilities such as Alberta Hospital Edmonton, Alberta Hospital Ponoka and the large acute care hospitals with psychiatric units. Similarity of caseloads, client type, and office environment only increase the level of concern and identification with the fatal incident.

In the more rural settings throughout Alberta, however, both

management and professional staff tend to diminish the volume and significance of personal risks to employees. This attitude is reflected in comments such as "We don't see ourselves as being at any more risk than if we were operating a doctor's office or a guidance counsellor's office". Two possible factors are that the severity of illness is not as great in the rural clinics and the client group is known by the community and the therapist. Therefore, potentially high risk "unknown" clients such as walk-ins or referrals from other agencies are perceived to be less risky. Some regions also refer the higher risk "crisis" patients to the psychiatric wards of the hospital. While isolation from other staff in an office setting is considered "risky," it can be perceived to be more "risky" to drive long distances to visiting clinics on treacherous winter road conditions than any client related risk that may be there upon arrival.

The tendency towards friendliness and openness in the smaller centres also affects the perception of risk and therefore impacts the design of any future enhancements to the clinic (absence of locks, counters, etc.).

It is perceived, by many clinical staff, that "non-client" risk can be greater than client risk. For example, husbands of battered women or wife abusers are considered a major risk when women are being counselled. If the woman is seeing a male therapist, this risk takes on a different dimension but it is nonetheless also there for female therapists as well.

Regardless of the setting (urban or rural) it is felt that the attitude of the therapist, Area or Clinic Manager, or even Regional Director can have a large impact on the perception of risk. There is an evident variation in the level of caution exercised by clinic staff with respect to client contacts. At the present time, these differences could impact on the development and implementation of policies and procedures, the design or operation of the physical clinic plant, or general attention to safety detail within the clinic/office environment.

**Management of Risk**

Staff attitude and expectation of risk are important variables. Staff must feel safe if they are to carry out an appropriate assessment but this may sometimes lead to denial, convincing oneself one is safe when in fact a risk is present. If the possibility of risk is identified, then appropriate actions should be taken. These would include interviewing the client in an alternative "intake" room with two exits and increased observation, having a colleague or colleagues present, paying attention to one's dress and physical defense, considering postponing or terminating the interview, summoning the police, or a combination of these.

The management of violent behaviour associated with mental illness is complex. For example, if caused by organic disorders, management involves investigation in a suitable environment (emergency department or in-patient unit) and treatment of the physical cause. Verbal intervention is of little value, medication may not be appropriate at least until the cause is determined and the behaviour is unlikely to be modified by the presence of police or security. If caused by delusional ideas in schizophrenia, medication is the treatment of choice, verbal intervention is difficult and behaviour is not likely to be modified by the presence of police because the client may feel that the violence is justified. Violence associated with personality disorder will often be modified by the presence of police or security and a skilled therapist can often use verbal intervention to defuse the situation. Restraint will sometimes be necessary in all of these cases.

As a result of this complexity, it is not realistic to expect that therapists will always be able to discern the risk and select and implement the most appropriate intervention. In such situations, clinical staff must rely on the appropriateness and effectiveness of alternate emergency measures.

## VII CONFLICTING PRIORITIES

After a horrifying incident such as the murder of a therapist, it is natural to feel or believe that security needs to be increased in many areas. The Committee has been impressed, however, by information received from management and professional staff in Edmonton and throughout the province that there is a need to balance security enhancement actions against other realities or principles. The conflicting priorities, or "tensions," which have been identified include:

### 1. Normalization

Many staff feel that it is important from a therapeutic point of view to treat patients, particularly patients with chronic mental illness, in as "normal" an environment as possible. Clinic staff remark that this was one of the reasons why the clinic system was established in the first place, namely to allow patients to be seen in an acceptable non-institutional environment. In the design of the older clinics within the system, there was a conscious decision not to include many of the physical barriers, locking mechanisms, and so forth that would enhance staff safety and security. The reality is that newer clinics must be designed, and older clinics possibly modified, to reflect a more appropriate balance between the normalization of the client and the safety and security of the staff.

**2. Stigmatization**

Many staff expressed their concern that patients with mental illness, particularly the chronically mentally ill, are stigmatized within society and that increasing levels of security will tend to feed the public fantasy of mental illness being associated with violence. Staff recognize that it is only for certain types of patients suffering from mental illness that violence is actually a problem. Therefore widespread actions that would treat all clients as potentially and equally violent could possibly enhance staff safety and security but it would be at the expense of unnecessarily increasing the stigmatization of the mentally ill. There must be a balanced approach to this problem.

**3. Client Confidentiality**

While it is clear that certain procedures, such as interviewing clients in an open visible area with auditory monitoring, are likely to improve security, nevertheless this conflicts with the confidentiality issue in that clients have the right to expect that their communications will be treated in a private manner. Design issues for waiting areas, intake rooms, and therapist offices (eg. soundproofing, windows, etc.) all have to achieve an acceptable compromise between security and confidentiality. In addition, client confidentiality with respect to file security must also be balanced with therapist security. The requirement, or type, of lock on the office door of therapists is a key issue in this regard.

**4. Openness and Informality**

Therapists recognize that openness and informality are important factors in a therapeutic relationship. They understand that therapy is more effective if it is conducted in an atmosphere of friendliness, warmth and trust. It is also clear, however, that openness and informality (ie. the absence of physical barriers, locks, doors, or security staff) can significantly reduce the personal security of the therapist. Another dimension of the openness issue is staff anonymity. On the one hand, in an open relationship clients have a right to know who their therapist is. Some staff particularly in larger centres are concerned about their personal safety after working hours and felt that staff anonymity by not wearing ID cards, not handing out business cards, not having the therapist name on the door or desk, and not leaving visible correspondence on a desk would decrease the client's ability to track the therapist's name and address. Again, a "comfortable" compromise is needed.

**5. Management Flexibility**

Management must be allowed the maximum amount of discretion possible with respect to implementing the Community Mental Health Services clinic program within numerous and variable constraints (eg. resource limitations, variations in clinic size, mandate, client mix, geography, etc.). However, management flexibility with respect to developing or implementing common appropriate policies, procedures, practices, or standards, or influencing the design and safety features of a clinic based on personal perception of risk, must be balanced with the responsibility of the Community Mental Health Services program and individual managers within the program to ensure the safety of program staff.

**6. Professionalism**

It is recognized that professional attitudes may in fact lead to problems in security. A professional person is often used to feeling comfortable, feeling that they are in control of the therapeutic situation, and these feelings will sometimes prevent recognition of a potentially explosive situation. In addition, it is "professionalism" which motivates clinic staff to advocate the greater enhancement of client confidentiality and acceptance, and openness and informality at the expense of personal security and safety.

**7. Resource Utilization/Limitations**

It is recognized that the provision of a safe working environment on a day to day basis as well as in the long term, including the implementation of some of this Committee's recommendations, may be constrained by the availability of Government resources. It is also recognized that some of the suggested security options would require more resources to facilitate lower caseloads, more security devices or redesign or relocation of clinics. However, the reality is that the vast majority of clinics will continue to operate out of their existing locations for the next several years with similar staffing and financial resource levels. Therefore security solutions need to be tailored to individual circumstances and balanced with resource realities.

**8. Physical Plant Limitations**

While it is recognized that some clinic locations have more safety attributes than others based on age, intent, risk and resource availability, almost all clinics have some physical plant "limitations" of one type or another. It would be anticipated that resolving those limitations would ensure staff safety and enhance security, although this can not be

absolutely guaranteed. Longer term issues like clinic relocation or redesign must be balanced against the comparative risk in other clinic locations and other uses of resources.

**9. Client Acceptability**

Because the Community Mental Health Services program is a voluntary program and is not imposed against the clients' will, it is recognized that the ultimate success of any safety and security enhancement measures will be the acceptance of the client community. Staff recognize that it is possible that some clients may be deterred from seeking help in a clinic characterized by highly visible security measures. Another dimension, however, is that it is also recognized that clients too may be reassured by reasonable safety precautions or behaviour limiting actions with respect to fellow clients. Therefore, whatever security measures are implemented to safeguard the clinic staff, they must meet with the acceptance of the client population.

**10. Deinstitutionalization**

It is recognized that the policy of deinstitutionalization has also created a security issue. The advantages of deinstitutionalization are clear, and include patients being treated in the community with greater freedom and potential for a more normal re-adjustment within the community setting. The security issues result from the potential for clients to choose not to participate in the community treatment programs, which could lead to a worsening of their symptoms, including violent behaviour.

In all of the above areas the Committee recognizes, and believes that the staff of the Community Mental Health clinic program would recognize, that the desire for greater safety and security inevitably has to be balanced against the competing or conflicting realities and priorities. All recommendations in this report attempt to strike this necessary balance.

**VIII. RECOMMENDATIONS:**

Based on the above information and analysis, the Committee makes the following recommendations with respect to the Community Mental Health Services clinic system's organization and mandate, physical plant, policies and procedures, training process, and other operational considerations as they relate to staff safety and security. The recommendations are not listed in priority order.

In developing the following recommendations, the Committee reviewed the recommendations contained in the Fatality Review - Inette John for possible province wide application. Where possible, to ensure consistency and to enable cross referencing, the earlier recommendations have either been reproduced in their entirety or amended somewhat to reflect the provincial perspective in application. References to the earlier recommendations are included where appropriate.

1. **Organization and Mandate**

1.1 The Mental Health Division should continue to attend to and focus available resources to the seriously mentally ill on a priority basis through:

1.1.1 Increasing access to higher levels of care through collaboration or liaison with twenty four hour care facilities. This would assist in stabilizing the more disturbed/higher risk clients while the clinic staff remain the primary caregivers in the community (Fatality Review recommendation #16).

1.1.2 Exploring the provision of non hospital-based alternatives that provide an ongoing secure environment for the dangerously mentally ill.

1.1.3 Developing options to respond to immediate dangerous situations in the community with the seriously mentally ill.

1.2 Review existing caseloads, priorization practices, utilization rates, referral sources, staffing, division of labour, roles, and objectives of the Community Mental Health Services clinic system. Assess its function, role and status with respect to the larger mental health system and its stakeholders province wide (Fatality Review recommendation #17).

1.3 Formalize the relationship between urban clinics and established specialist forensic programs. In rural clinics establish appropriate protocols with probation,

parole, and police services to deal with high risk forensic clients.

1.4 Programs for people with a combination of substance abuse and mental illness should be a priority.

## 2. Physical Plant/Security

2.1 Undertake a detailed review of each clinic office to determine the overall attention to safety details, level of staff safety and security awareness, as well as the possible requirement for structural changes or the installation of other devices to achieve a greater level of safety and security. The Committee offers its services to assist in the development of a comprehensive clinic review checklist.

2.2 Install appropriate buzzer/alarm systems in each Community Mental Health Services clinic in order to bridge the identified "isolation gap". The nature of the system will need to vary based on size of clinic, location of backup responder, and unique requirements of visiting clinics. As a general rule, however, all systems should include the following features:

- Accessibility by all clinic staff
- Specific identification of emergency location
- General clinic alarm wherever possible, as opposed to sounding at a specific location

Beyond these common features, appropriate experts such as Alberta Public Works, Supply and Services, Security Services should be consulted with respect to developing the detailed alarm system standards for each clinic type.

2.3 Community Mental Health Services clinic safety and security standards be developed jointly between Mental Health, Accommodations, and Public Works, Supply and Services for future relocation or renovation projects. In addition to dealing with such general issues as location within the building to prevent isolation, alternatives to the solid general office doors, provision of a second exit door, and minimization of risk associated with interior hallways, specific standards should also address:

Waiting Area/Reception

- intake room requirements/specifications/evaluation criteria
- restricted access between waiting area and interior

of clinic
- type of reception counter required (conditions for use of plexiglass barrier)

Therapist Office/Interview Room

- Soundproofing standards and specifications
- Interior window location and specifications
- Typical furniture plan showing electrical/telephone and buzzer/alarm system placement
- Type of lock, if any, on door

Therapy/Observation Rooms

- Technical specifications re: soundproofing, one-way mirror, sound systems, furniture, colour schemes and so on.

These standards should form a "minimum starting point" for all future development and renovation work. The standards will have to provide flexibility for variation in size and type of clinic. However, alteration of construction standards based on personal perception of risk must not be allowed. Alteration of furniture placement within an office may be allowed with approval of Area or Clinic Manager as long as "standard" wiring and safety objectives are not compromised. If an office has been altered, it should be returned to standard upon hiring a new employee. (Fatality Review recommendations #7 and #8)

## 3. Policies and Procedures

3.1 Policies and procedures listed on page 9 require review and development by the Community Mental Health Services Provincial Policy and Procedure Review Committee. Once approved, the policies must form the minimum standard for consistent action and implementation throughout the clinic system. Regional variation could exist beyond the basic policy outline, but not within it. This Committee offers its services to provide advice and direction to the Policy Review Committee in developing these standards and procedures. (Fatality Review recommendation 3)

The following items are highlights of this Committee's findings and should be included when developing policies and procedures:

3.1.1 **Incident reporting:** Standardized definition, documentation, and format; copy on client file; review and analysis at clinical,

regional, and provincial levels; and feedback/ response process to the report originator.

3.1.2 **Intake process:** Designated person and process available during clinic hours of operation; secure location with high visibility and ease of exit; and availability of backup resources (Fatality Review recommendations #10 and 14).

3.1.3 **Emergency evacuation/response:** Alert system; appropriate response personnel and process; with designated and knowledgeable backup (Fatality Review recommendation #12).

3.1.4 **Caution indicators:** Provincial consistency; circumstances for use; level of awareness; ensure notation on file and computer systems; and some form of risk analysis.

3.1.5 **Home visits:** Pre-authorized under specific circumstances; clinic knows exact schedule and whereabouts; two therapists if difficulties expected; police as backup.

3.1.6 **Difficult clients:** Definition; designated area to see client with safety exit; internal backup resources and police backup; and dealing with threats.

3.1.7 **Unacceptable behaviour limits:** Set limits for waiting area and therapy; ensure enforcement of same consistently by all clinic staff; contingency plans in place if limits exceeded.

3.1.8 **Critical incident debriefing:** Definition; the appropriate format, personnel, and timing.

3.1.9 **Clinic safety detail:** Appropriate furniture layout; awareness of safety/security features of clinic; and awareness of possible use of decorating or office items as weapons.

## 4. Training and Orientation

4.1 Formal ongoing training and orientation programs for management, clinical, and administrative support (including temporary) staff be developed to ensure adequate knowledge and familiarity with:

- all relevant policies and procedures

- diagnostic categories and behaviour cues which would predict increased risk of violence
- risk management and personal safety techniques
- office layout and design safety issues and standards
- location and availability of back up and use of police and other agencies

(Fatality Review recommendation #4)

4.2 In small and visiting clinics, train backup responders with other agencies. As these people could receive a distress call from clinic staff, they need to be familiar with expectations and processes involved in having that responsibility. With normal staff changes and turnover, attention needs to be given to ensuring that all people acting in the capacity of responder are ready and able to provide the timely and effective response required.

4.3 Formally drill or practise security procedures in every clinic on a regular (ie. semi annual) basis. Attend to specific response oriented polices and procedures including:

- medical emergencies
- distress calls from therapists in therapy or intake situations
- reception distress calls
- emergency evacuation

Drills are to be used to test policies and procedures with a view to improving them when weaknesses or gaps are uncovered. Annual inspections of each worksite should be carried out.

## 5. Clinical Operations

5.1 Review the role of the Area Clinic Manager with respect to safety and security issues. Whenever possible, immediate safety response requirements should be delegated to a senior therapist in the clinic, at least on a back up basis. The Area Manager and Regional Director should be responsible for ensuring that policies and procedures are developed, adequately communicated, and implemented and that a high level of emergency "readiness" is in place.

5.2 Consider identification badges, worn by all clinic staff as an option where clinic size or other factors (eg. new or temporary staff) warrant them. If implemented, staff anonymity should be ensured by indicating only a first

name or an identifying number on the badge, instead of the employee's full name (Fatality Review recommendation #2).

5.3 Establish mechanisms such as a "central registry" or other special notice protocols for intradivisional (ie. within the Community Mental Health Services clinic system of Alberta Health) and interagency (ie. Alberta Hospital Edmonton and Ponoka, Psychiatric Units, Alberta Family and Social Services, etc.) communication and collaboration as a means of identifying, notifying, and informing one another of high risk clients (Fatality Review recommendation #15).

5.4 Ensure that clerical/reception staff have knowledge of intake schedules and therapists' whereabouts throughout the day. Protocol for seeing "walk-ins" or emergency cases needs to be established and implemented. Ensure that clerical/reception staff are alerted to problematic incoming appointments. Clinics must be kept informed of the location and timing of therapists' home, agency, or travelling clinic visits, including the expected time of return (Fatality Review recommendation #9).

5.5 Recognizing that the prediction of dangerousness is best achieved through knowledge of the client review clinical practice to ensure adequate time for assessment. Review the benefits and feasibility of obtaining psychiatric consultation and assessment of "at risk" clients, following initial screening and prior to the commencement of therapy. Procedures should be in place in each clinic to effectively manage violent behaviour.

## IX. SUMMARY:

On August 27, 1991 Inette John was stabbed to death by a former client. This gave rise to the formation of a security review committee to investigate the fatality and to assess the security of the overall Community Mental Health Services clinic system.

The committee reviewed the program organization and mandate, physical plant security, and policies and procedures in existence at the time of the incident. An attempt was made to quantify the prevalence of risk throughout the clinic system through analysis of the Caution Indicator and Incident Reporting systems and consultation/visitation with the six program regions.

Based on the above process, the committee concluded that the level of risk, while not able to be measured precisely, is significant enough to merit consideration and attention to factors which would, upon implementation, improve staff safety and security. Secondly, the committee identified ten dilemmas which highlight the complexity in which the clinic system must operate. These complexities were considered in developing the recommendations of this report.

The Committee does not believe that employee personal safety can be guaranteed, but does believe that by attending to security issues from a holistic perspective that potential risk to employees of Alberta Health can be minimized.

## APPENDIX I

## PERMANENT MENTAL HEALTH OFFICES

**EDMONTON REGION:**

108 Street Building (Edmonton)
Ft. Saskatchewan
St. Albert
Stony Plain
Hinton
Drayton Valley
Leduc
Sherwood Park
Edson

**NORTHWEST REGION:**

Grande Prairie
Grande Cache
High Prairie
Whitecourt
Peace River
Barrhead
Slave Lake

**NORTHEAST REGION:**

Fort McMurray
Lac La Biche
St. Paul
Vegreville
Athabasca
Westlock
Bonnyville
Vermilion

**CENTRAL REGION:**

Red Deer
Provost
Wainwright
Lacombe
Wetaskiwin
Olds
Hanna
Camrose
Stettler
Ponoka
Rimbey
Rocky Mountain House
Drumheller

**CALGARY REGION:**

Central Calgary Clinic
Strathmore
Airdrie
Cochrane
East Calgary
Northeast Calgary
Canmore
High River

**SOUTH REGION:**

Lethbridge
Brooks
Medicine Hat
Taber
Blairmore
Claresholm
Pincher Creek

## VISITING MENTAL HEALTH OFFICES

**EDMONTON REGION:**

Jasper
Red Water

**NORTHWEST REGION:**

Beaver Lodge
Valleyview
Mayerthorpe
Manning
Fairview
Spirit River
Swan Hills
McLennan
Cadotte lake
Fox Creek

**NORTHEAST REGION:**

Fort Chipewyan
Smokey Lake
Grande Centre

**CENTRAL REGION:**

Three Hills
Carstairs
Trouchu
Consort
Castor
Hobbema
Buck Lake
Innisfail
Didsbury
Sundre
Coronation
Tofield
Winfield
Alder Flats

**CALGARY REGION:**

Banff
Gleichen
Eden Valley
Black Diamond

**SOUTH REGION:**

Cardston
Nanton
Milk River
Vulcan
Warner